MARYLAND Department of Health

Arboviral/Encephalitis/Aseptic Meningitis Surveillance Form

PATIENT INFORMATION

First Name: _____ Middle Name: _____
Last Name: _____ Suffix: _____
Country of birth: _____
Date of birth: _____ Reported age: _____
Current Sex: ◯ Female ◯ Male ◯ Unknown

Is the patient deceased? ◯ Yes ◯ No ◯ Unknown If yes, deceased date: _____
Marital status: ◯ Annulled ◯ Divorced ◯ Domestic partner ◯ Interlocutory ◯ Legally separated
◯ Married ◯ Polygamous ◯ Refused to answer ◯ Single, never married
◯ Unknown ◯ Widowed

Address information
Street Address: _____
City: _____
State: _____
Zip: _____
County: _____
Country: _____

Home phone: _____
Work phone: _____
Ext: _____
Cell phone: _____
Email: _____

Ethnicity: ◯ Hispanic or Latino ◯ Not Hispanic or Latino ◯ Unknown

Race (Select all that apply):
◯ American Indian or Alaska Native
◯ Asian
◯ Black or African American
◯ Native Hawaiian or Other Pacific Islander
◯ White
◯ Unknown

CASE INFORMATION

Investigator information

Jurisdiction: _____ Investigation start date: _____
Investigator Name: _____ Date assigned to investigation: _____
Date of report: _____
Earliest date reported to county: _____
Earliest date reported to state: _____

Reporting source type:
◯ Blood bank ◯ Correctional facilities ◯ Data registries
◯ Daycare facility ◯ Dentist ◯ Drug treatment facility
◯ Emergency room/emergency department ◯ Family planning facility
◯ Hospital ◯ Indian Health Service ◯ Laboratory
◯ Managed Care/HMOs ◯ Military ◯ National job training program
◯ Other federal agencies ◯ Other state or local agencies
◯ Other treatment center ◯ Pharmacy ◯ Prenatal/Obstetrics facility
◯ Private physician's office ◯ Public health clinic
◯ Public health clinic – HIV ◯ Public health clinic– STD
◯ Public health clinic – TB ◯ Rural health clinic ◯ School clinic
◯ Tribal government ◯ Veterinary sources ◯ Vital statistics

Reporting organization: _____
Address: _____

Reporting provider: _____
Address: _____

Clinical Information

Physician: _____
Address: _____

Was the patient hospitalized for this illness? ◯ Yes ◯ No ◯ Unknown
If yes, name of hospital: _____
Admission date: _____ Discharge date: _____
Total duration of stay: _____

Type of arbovirus:
◯ Arbovirus ◯ Cache valley virus ◯ California encephalitis virus
◯ Chikungunya virus ◯ Colorado tick fever virus ◯ Dengue virus
◯ Eastern equine encephalitis virus ◯ Flavivirus ◯ Jamestown Canyon virus
◯ Japanese encephalitis virus ◯ La Crosse virus ◯ Powassan virus
◯ St. Louis encephalitis virus ◯ Venezuelan equine encephalomyelitis virus
◯ West Nile ◯ Western equine encephalitis virus ◯ Yellow fever ◯ Zika virus

Clinical syndrome (Select one): ◯ Acute flaccid paralysis ◯ Asymptomatic ◯ Congenital infection
◯ Dengue ◯ Dengue-like illness
◯ Encephalitis – including meningioencephalitis
◯ Febrile illness ◯ Guillain-Barre syndrome ◯ Hepatitis/Jaundice
◯ Meningitis ◯ Multiple organ failure ◯ Other clinical
◯ Other neuroinvasive presentation ◯ Unknown

If Other clinical, note syndrome: _____

Clinical syndrome, secondary (Select one):
◯ Acute flaccid paralysis ◯ Encephalitis – including meningioencephalitis
◯ Guillain-Barre syndrome ◯ Hepatitis/Jaundice ◯ Meningitis
◯ Multi-system organ failure ◯ None ◯ Other clinical
◯ Other neuroinvasive presentation

If Other clinical, note syndrome: _____

Diagnosis date:_____ Illness onset date: _____

Illness end date: _____ Illness duration: _____

Age at onset: _____ Did the patient die from this illness?◯ Yes ◯ No ◯ Unknown

If yes, date of death: _____

Pregnancy and birth information

Is the patient pregnant? ◯ Yes ◯ No ◯ Unknown If yes, due date: _____

Pregnancy complications (Select all that apply):
◯ Fetal growth abnormality
◯ Fetus with Central Nervous System (CNS) abnormalities
◯ Intracranial calcification
◯ Microcephaly

Pregnancy outcome (Select one):
◯ Delivery (live birth) ◯ Fetal death (fetal loss) ◯ Perinatal death
◯ Premature death of newborn ◯ Still pregnant
◯ Stillbirth (Intrauterine fetal death)
◯ Therapeutic termination of pregnancy

Mother's last menstrual period before delivery: _____

Newborn complications (Select all that apply):
◯ Congenital anomaly of central nervous system ◯ Intracranial calcification
◯ Intrauterine Growth Retardation (IUGR) ◯ Limb defects ◯ Microcephaly
◯ None ◯ Ocular defects

Mother-infant case ID linkage 1: _____

Mother-infant case ID linkage 2: _____

Mother-infant case ID linkage 3: _____

Signs and symptoms

Fever: ◯ Yes ◯ No ◯ Unknown

Chills or rigors: ◯ Yes ◯ No ◯ Unknown

Fatigue or malaise: ◯ Yes ◯ No ◯ Unknown

Rash:	◯ Yes	◯ No	◯ Unknown
Headache:	◯ Yes	◯ No	◯ Unknown
Myalgia:	◯ Yes	◯ No	◯ Unknown
Arthralgia:	◯ Yes	◯ No	◯ Unknown
Arthritis:	◯ Yes	◯ No	◯ Unknown
Paralysis or paresis:	◯ Yes	◯ No	◯ Unknown
Stiff neck:	◯ Yes	◯ No	◯ Unknown
Ataxia:	◯ Yes	◯ No	◯ Unknown
Parkinsonism or cogwheel rigidity:	◯ Yes	◯ No	◯ Unknown
Altered mental status:	◯ Yes	◯ No	◯ Unknown
Seizures:	◯ Yes	◯ No	◯ Unknown
Conjunctivitis:	◯ Yes	◯ No	◯ Unknown
Retro-orbital pain:	◯ Yes	◯ No	◯ Unknown
Nausea or vomiting:	◯ Yes	◯ No	◯ Unknown
Diarrhea:	◯ Yes	◯ No	◯ Unknown
Abdominal pain or tenderness:	◯ Yes	◯ No	◯ Unknown
Persistent vomiting:	◯ Yes	◯ No	◯ Unknown
Liver enlargement (hepatomegaly):	◯ Yes	◯ No	◯ Unknown
Oral ulcer:	◯ Yes	◯ No	◯ Unknown
Extravascular fluid accumulation:	◯ Yes	◯ No	◯ Unknown
Mucosal bleeding:	◯ Yes	◯ No	◯ Unknown
Severe plasma leakage:	◯ Yes	◯ No	◯ Unknown
Sever bleeding:	◯ Yes	◯ No	◯ Unknown
Tourniquet test positive:	◯ Yes	◯ No	◯ Unknown
Increasing hematocrit and decreased platelet:	◯ Yes	◯ No	◯ Unknown
Sever organ involvement:	◯ Yes	◯ No	◯ Unknown
Leukopenia:	◯ Yes	◯ No	◯ Unknown

Other symptoms: _____

_____

Epidemiologic

Is this case part of an outbreak? ◯ Yes ◯ No ◯ Unknown

If yes, outbreak name:

_____

Did the patient travel outside home COUNTY in the two weeks before symptom onset?

◯ Yes ◯ No ◯ Unknown If yes, where to and when: _____

Where was the disease acquired? (Select one)

◯ Imported, but not able to determine source state and/or county
◯ In state, out of jurisdiction
◯ Indigenous
◯ International
◯ Out of state
◯ Unknown

If disease was acquired [In state, out of jurisdiction] or [International] or [Out of State], please fill in location:

Country: _____ State: _____

City: _____ County: _____

Country of usual residence:

_____

Has the patient spent extended time outdoors in the 2 weeks prior to onset? ◯ Yes ◯ No ◯ Unknown

Has the patient traveled outside Maryland in the 2 weeks prior to onset? ◯ Yes ◯ No ◯ Unknown

If yes, specify when and where (geographic location): _____

Binational reporting criteria (Select all that apply):

◯ Exposure to suspected product from Canada or Mexico
◯ Has case contacts in or From Mexico or Canada
◯ Other situations that may require binational notification/coordination of response
◯ Potentially exposed by a resident of Mexico or Canada
◯ Potentially exposed while in Mexico or Canada
◯ Resident of Canada or Mexico

Occupationally lab acquired: ◯ Yes ◯ No ◯ Unknown

Identified by blood donor screening: ◯ Yes ◯ No ◯ Unknown

Blood donor: ◯ Yes ◯ No ◯ Unknown

If yes, specify (donated blood products in the 2 weeks prior to onset of symptoms): _____

Date of donation: _____

Blood transfusion received: ◯ Yes ◯ No ◯ Unknown

Organ donor: ◯ Yes ◯ No ◯ Unknown

Organ transplant received: ◯ Yes ◯ No ◯ Unknown

Breast fed infant: ◯ Yes ◯ No ◯ Unknown

Arboviral disease transmission mode (Select one) :

◯ Blood borne transmission ◯ In-Utero (Transplacental)
◯ Indeterminate transmission mode ◯ Other ◯ Perinatal exposure
◯ Sexual transmission ◯ Vector-borne transmission

Infected in utero: ◯ Yes ◯ No ◯ Unknown

Ill Contact Name	**Ill Contact Phone Number**

Laboratory findings

Test Type	**Result**	**Specimen Type**	**Collection Date**	**Performing Lab Type**

Cerebrospinal fluid (CSF) pleocytosis (≥5WBC): ◯ Yes ◯ No
Serum paired antibody test interpretation: ◯ ≥ 4 fold rise ◯ Negative ◯ Positive ◯ Test not done
Deng (DENV) serotype (for Dengue only): ◯ Type 1 ◯ Type 2 ◯ Type 3 ◯ Type 4 ◯ Unknown

Vaccination Status

Did the patient ever receive vaccine for:

Yellow fever	◯ Yes	◯ No	◯ Unknown	If Yes, date: _____
Japanese encephalitis	◯ Yes	◯ No	◯ Unknown	If Yes, date: _____
Tick-borne encephalitis	◯ Yes	◯ No	◯ Unknown	If Yes, date: _____

For Zika only:

Sexual contact with anyone who traveled to or resided in an area with active/endemic transmission?
◯ Yes ◯ No ◯ Unknown
If Yes, partner's travel from date: _____ Partner's travel to date: _____
If Yes, partner's travel location(s): _____
If Yes, was the sexual partner symptomatic during or within 2 weeks after travel?
◯ Yes ◯ No ◯ Unknown If Yes, partner's date of onset: _____
Date of last sexual contact (if known): _____
Name of sexual partner: _____

General comments

_____
_____
_____
_____
_____